

**Direct Contract Provider  
MONTHLY INTERIM PAYMENT CLAIM  
For**

**Drug/Medi-Cal (D/MC) State General Funds (SGF) - Fiscal Year 1999-00**

Direct Provider Name: \_\_\_\_\_

Mailing Address

CHECK ONE FOR EACH LINE:

☐ Non-Perinatal (20) ☐ Perinatal (25)☐ Non-Minor Consent ☐ Minor Consent

ADP Contract # \_\_\_\_\_

D/MC Provider #: \_\_\_\_\_

Mo/Yr of Claim \_\_\_\_\_

**NARCOTIC TREATMENT PROGRAMS (NTP)**

Type of Service	SFC	Projected Units of Service	Cost Per Unit of Service	NET CLAIM
Methadone	20-22			
LAAM	23-25			
Individual Counseling	26-27			
Group Counseling	28-29			
<b>FEDERAL AND STATE SHARE SUB-TOTAL</b>				

**OTHER DRUG/MEDI-CAL MODALITIES**

Type of Service	SFC	Projected Units of Service	Cost Per Unit of Service	NET CLAIM
Day Care Habilitative	30-39			
Outpatient Drug Free - Indiv.	80-84			
Outpatient Drug Free - Group	85-89			
Naltrexone	50-59			
Perinatal Residential	40-49			
<b>FEDERAL AND STATE SHARE SUB-TOTAL</b>				

**GRAND TOTAL** (Federal and State Share) - NTP & Other Drug/Medi-Cal Modalities

Signature of Fiscal Representative

Date

Typed Name of Fiscal Representative

Telephone Number

**ADP PROGRAM CERTIFICATION**

I hereby certify that this request is in accordance with the existing contract and is approved for payment.

**TOTAL STATE GENERAL FUNDS (48.45% for 7/1/99 to 9/30/99 and 48.33% for 10/1/99 to 6/30/00  
- Except for Regular Alcohol/Drug Minor Consent(\*))**

ADP Analyst Approval

Date

**Direct Contract Provider**  
**MONTHLY INTERIM PAYMENT CLAIM**  
**For Drug/Medi-Cal (D/MC) State General Funds (SGF) –**  
**Fiscal Year 1999-00**

**Completion Instructions for Form 7890 (7/99)**

1. Direct Provider Name: Enter the Direct Provider name.
2. Check One for Each Line: Make sure that you check each line for the following areas:  
-Non-Perinatal (20) or Perinatal (25)  
-Non-Minor Consent or Minor Consent
3. Mailing Address: Enter the mailing address for the provider.
4. ADP Contract Number: Enter the contract number assigned for Fiscal Year 1999-00.
5. DMC Provider #: Enter the DMC Provider number issued by ADP Licensing and Certification for the purpose of billing for DMC services.
6. Mo/Yr of Claim: Enter the month and year of when projected services will be provided.
7. Narcotic Treatment Programs (NTP):
  - a. Projected Units of Service: Enter the projected units of service that will be provided for the claims month/year for each applicable type of service.
  - b. Cost Per Unit of Service: Enter the amount up to the maximum allowance rate amount for each applicable type of service.
  - c. NET CLAIM: For each applicable type of service, enter the amount based on the multiplication of the Projected Units of Service and the Cost Per Unit of Service.
  - d. Federal and State Share Sub-Total: Enter the total of all the NTP Net Claim amounts.
8. Other Drug Medi-Cal Modalities:
  - a. Projected Units of Service: Enter the projected units of service that will be provided for the claims month/year for each applicable type of service.
  - b. Cost Per Unit of Service: Enter the amount up to the maximum allowance rate amount for each applicable type of service.
  - c. NET CLAIM: For each applicable type of service, enter the amount based on the multiplication of the Projected Units of Service and the Cost Per Unit of Service.
  - d. Federal and State Share Sub-Total: Enter the total of all the NTP Net Claim amounts.
9. Grand Total: Enter the total of both Sub-Totals.
10. Signature of Fiscal Representative: To be signed by the authorized person.
11. Type Name of Fiscal Representative: Enter the typed name of the authorized person signing the form.
12. Date: Enter the date the authorized person signed the form.
13. Telephone Number: Enter the telephone number of the authorized person.
14. Submit the completed forms to:

Department of Alcohol and Drug Programs  
Fiscal Management Branch  
1700 K Street, Fourth Floor  
Sacramento, CA 95814-4037

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**ADP PROGRAM CERTIFICATION**

ADP staff will review request, calculate the State General Fund amount that will be reimbursed, and issue approval if acceptable. Upon approval, ADP staff will return an approved copy of the claim to the Direct Contract Provider.

The State General Fund calculations will be made based on the following:

- a. For the time period July 1, 1999 through September 30, 1999 – multiply the Grand Total by 48.45%, including Perinatal Minor Consent, but not for Regular Alcohol Drug Minor Consent (\*).
- b. For the time period October 1, 1999 through June 30, 2000 – multiply the Grand Total by 48.33%, including Perinatal Minor Consent, but not for Regular Alcohol Drug Minor Consent (\*).
- (\*) For Regular Alcohol Drug Minor Consent for the entire fiscal year – the same amount identified in the Grand Total will be identified in the State General Fund Total (100%).